Patient Information	
Name (legal name)	
Date of Birth *(MM/DD/YYYY)*	
Address	
City, State, Zip	
Phone	
Email	
Medical Insurance	
MEDICAL POLICY NAME	
ID (all #s/letters)	
Group #	
Primary Member's Info (Subscriber Member)	
Legal Name	
Date of Birth	
Last 4 of SS	
Primary Healthcare Provider or Referrer	
Name of Clinic	
Primary Care Provider	
Address/Location	
Telephone	
Fax	

Reason for Examination

☐ Comprehensive Eye Examination
☐ Neuro-Optometric Evaluation
☐ Contact Lens Evaluation/Updated Contact Lens RX
☐ Diabetic Eye Exam
☐ Office Visit (red eye, floaters, eye pain, etc.)
☐ Special Testing

Current/History of Eye Problems			
Blurry @ distance?	☐ Yes ☐ No	*Light sensitivity?*	☐ Yes ☐ No
Blurry @ near?	☐ Yes ☐ No	*Eye strain?*	☐ Yes ☐ No
Flashes in vision?	☐ Yes ☐ No	*Dry eyes?*	☐ Yes ☐ No
Floaters?	☐ Yes ☐ No	*Tearing/watery eyes?*	☐ Yes ☐ No
Vision loss?	☐ Yes ☐ No	*Eye Pain?*	☐ Yes ☐ No
Headaches?	☐ Yes ☐ No	*Itchy eyes?*	☐ Yes ☐ No
Double vision?	☐ Yes ☐ No	*Burning?*	☐ Yes ☐ No
Eye turn?	☐ Yes ☐ No	*Burning?*	☐ Yes ☐ No
Glasses/Contacts Wearer?		☐Glasses ☐Contacts ☐Both	
Last eye exam? (MM/YYYY)			
History of eye dilation?		☐ Yes ☐ No ☐ Unknown	

Medical Eye History	Self	Family ☐N/A
Glaucoma/Glaucoma Suspect	☐ Yes ☐ No	☐ Yes ☐ No
Lazy eye/strabismus?	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	
Retinal Detachment	☐ Yes ☐ No	
Eye trauma or foreign body?	☐ Yes ☐ No	
Past Eye Surgeries	☐ Yes ☐ No	

Medical History		Self	Family
* Check "Y" if the condition applies to you; ☐ Adopted/Unknown Fam Hx			
General Endocrine	Weight change	☐ Y	
	Fever	☐ Y	
	Appetite change	☐ Y	
	Pregnant/Nursing	☐ Y	
	Fatigue	☐ Y	
	Hx of Cancer?	☐ Y	
Ear, Nose, & Throat	Cough? Runny Nose?	☐ Y	
	Dry mouth?	☐ Y	
	Hearing Changes?	☐ Y	
	Sinus Problems?	☐ Y	
Cardiovascular	Heart Disease?	☐ Y	☐ Y
	High Cholesterol?	☐ Y	
	High blood pressure?	☐ Y	☐ Y
	Arrhythmia?	☐ Y	
Respiratory?	Sleep apnea?	☐ Y	
	Asthma	☐ Y	
	Loud Snoring?	☐ Y	
	Sarcoidosis?	☐ Y	
	COPD	☐ Y	
Genitourinary & Kidney	Kidney disease?	☐ Y	
	Prostate problems?	☐ Y	
Musculoskeletal	Arthritis?	☐ Y	
	Joint Pain?	☐ Y	
Gastrointestinal	Crohn's disease?	☐ Y	
	IBS?	☐ Y	
	Acid Reflux	☐ Y	
Skin	Eczema?	☐ Y	
	Ehler's Danlos?	☐ Y	
	Rosacea?	☐ Y	
Neurological	Headaches?	☐ Y	
	Migraines?	☐ Y	
	Concussion?	☐ Y	
	Stroke?	☐ Y	
	Seizures?	☐ Y	
	Multiple Sclerosis?	☐ Y	
	Alzheimer's	☐ Y	
	Balance Problems?	☐ Y	
	Brain Tumor?	☐ Y	
Psychiatric	ADHD?	☐ Y	
	Anxiety?	☐ Y	
	Depression?	☐ Y	
	PTSD?	☐ Y	
	Dyslexia?	☐ Y	
	Bi-Polar?	☐ Y	
Endocrine	Diabetes?	☐ Y	☐ Y
	Thyroid Disease?	☐ Y	☐ Y
	Anemia?	☐ Y	
Blood/lymph	Sickle Cell?	☐ Y	
	HIV?	☐ Y	
Allergic/Immunologic	Seasonal Allergies?	☐ Y	
	Herpes?	☐ Y	
	Lyme Dx?	☐ Y	
	Shingles?	☐ Y	
	Sjogren's Dx	☐ Y	
	Lupus	☐ Y	

Other Health Conditions			
List of Injuries/Surgeries			
List of ALL Medications	☐ None ☐ Yes (list) -		
List Eye Drops	☐ None	**Allergies to Medications**	☐ None ☐ Yes(list) -
Tobacco use?	☐ Yes-current ☐ Yes - Prior ☐ No	**Do you drink alcohol?**	☐ Yes ☐ No

SECTION 1 - Privacy Policy, Assignment of Insurance Benefits, Exam Reminder Program & Office

I understand that **Swoop Eye Care (SWP)** may use and disclose necessary personal health information (PHI) to another third party to permit SWP to perform administrative duties, provide me with eye care services and products, and to process my insurance claim(s). I acknowledge that I have either been given access to or received a copy of the "Notice of Privacy Practices".

If using insurance for your visit, please present all relevant information prior to your visit. I assign to Swoop Eye Care all medical plan payments, if any, otherwise payable to me for services rendered. I hereby authorize the release of personal health information (PHI) necessary to secure the payment of benefits by Swoop Eye Care or a third-party billing service for in-network plans. I acknowledge and authorize that Swoop Eye Care or third-party billing service may contact any phone number/address provided for billing purposes, practice announcements, & annual/office visit reminders.

I understand that I am financially responsible for all charges not covered by your insurance related to my visit(s). I also understand Swoop's $75 No Show or 24 hours Late Cancelation Fee. All copays, co-insurance, and deductible amounts (not met) are due at the time of service. Contact lens evaluation fees (not generally covered by insurance nor part of the comprehensive eye exam) are due at the time of service and are non-refundable. Contact evaluations/fittings must be completed within 60 days unless specified. I also consent to electronic delivery of a digital copy of my prescription(s) for glasses/contact lenses by email or text messaging systems.

I have read, acknowledge, and confirm Swoop's notice of privacy practices, assignment of insurance benefits, business practice policies, and that you have reviewed your insurance coverage.

Patient/ Guardian Signature:		Date:	

SECTION 2 - Motor Vehicle Accident or Injury While at Work

- Does your visit involve or relate to a motor vehicle accident? ☐No ☐Yes
- Does your visit pertain to an injury occurring at work? ☐No ☐Yes

SECTION 3 – INVOICE

- If your visit has a copay, co-insurance, or deductible payment due, select the best method to receive your bill (if not collected in office): ☐Email/Text ☐Email/Text/Mail

SECTION 4 - INFORMED Consent for Dilation and/or OPTOS IMAGING:

There are two ways to assess the health of the inside part of your eyes.

- ☐ **Option 1- DILATION (no cost):** Your optometrist instills an eye drop to check eye health after 20 minutes.
  - Dilation is recommended for - New patients to the practice, Change/increase in floaters or presence of flashes of light, Very nearsighted patients, Unexplained or change in vision or vision loss, Known eye or systemic medical conditions (diabetes, hypertension, cataracts, etc.)
  - Adverse side effects expected: Light sensitivity for 1-4 hours, Near vision blur for 1-3 hours
- ☐ **Option 2 - OPTOS IMAGING ($35):** The **i**mage allows your optometrist to evaluate your eye health without instilling eye drops for $35. Dilation may be recommended pending concerns.

SECTION 5 - OTHER

- How did you hear about us? _____
- Please provide a name of the referrer or prior patient? _____